Cooling methods used in the treatment of exertional heat illness

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Objective: To review the different methods of reducing body core temperature in patients with exertional heatstroke.

Methods: The search strategy included articles from 1966 to July 2003 using the databases Medline and Premedline, Embase, Evidence Based Medicine (EBM) reviews, SPORTDiscus, and cross referencing the bibliographies of relevant papers. Studies were included if they contained original data on cooling times or cooling rates in patients with heat illness or normal subjects who were subjected to heat stress.

Results: In total, 17 papers were included in the analysis. From the evidence currently available, the most effective method of reducing body core temperature appears to be immersion in iced water, although the practicalities of this treatment may limit its use. Other methods include both evaporative and invasive techniques, and the use of chemical agents such as dantrolene.

Conclusions: The main predictor of outcome in exertional heatstroke is the duration and degree of hyperthermia. Where possible, patients should be cooled using iced water immersion, but, if this is not possible, a combination of other techniques may be used to facilitate rapid cooling. There is no evidence to support the use of dantrolene in these patients. Further work should include a randomised trial comparing immersion and evaporative therapy in heatstroke patients.

Heat illness is an unchecked increase in body core temperature that occurs when intrinsic or extrinsic heat generation overwhelms homoeostatic thermoregulation. Consequential dysfunction at cellular and organ level results in a spectrum of disease from minor heat cramps through symptoms of heat exhaustion to life threatening heatstroke. Heatstroke is characterised by neurological disturbance associated with haematological abnormalities, and may result in multiorgan failure and death.

Classical or environmental heat illness occurs in those whose thermoregulatory control mechanisms are inefficient, such as the very young or elderly, and those subjected to extreme temperatures. The main factor in the development of this condition is a high environmental temperature, with clusters of cases occurring after heat waves (700 heat related deaths were reported after the Chicago heat wave of 1995) and the annual pilgrimages in the Middle East.

In contrast, exertional heat illness typically affects young athletes or military personnel, who are pushed to their physical limits and suffer a clinical and pathological syndrome caused by an inability to dissipate heat produced by muscular exercise. This can occur at any time of year, and is a reflection of intrinsic heat production rather than external heat. There are usually identifiable risk factors such as dehydration, concurrent illness, lack of sleep, obesity, alcohol ingestion, wearing too much clothing, or poor cardiovascular fitness. However, sometimes no precipitating factors are evident, and the reason why one individual is affected by heatstroke while others remain unaffected is not clearly understood.

Despite differences in their pathophysiology, the recommended treatment of these conditions is similar. An assessment of airway, breathing, and circulation should be the priority, and basic life support instituted if appropriate. High flow oxygen should be administered, intravenous access achieved, and initial observations should include a rectal temperature. Subsequently the emphasis is placed on reduction of core temperature as quickly as possible, as it has been suggested that the major determinant of outcome in heatstroke is the duration of hyperthermia. One case series found a trend towards improved survival in patients cooled to a core temperature below 38.9°C within 60 minutes, and another report found improved survival when patients were cooled to the same level within 30 minutes, although the methods of cooling are not explored in detail in this paper.

The evidence is limited, but what little there is would suggest that outcome may be improved when core temperature is reduced as quickly as possible. This remains the cornerstone of treatment of heatstroke patients, and is emphasised in the Inter-Association Task Force on Exertional Heat Illness consensus statement.

Several methods of body cooling have been described, as outlined in box 1. The evidence to support one method over the other is limited and appears contradictory, and authors have proposed there is no evidence one way or the other. The aim of this review is therefore to examine and appraise this evidence, and give a summary and recommendations based on its findings.

METHODS

A comprehensive search of the literature was carried out, using Medline and Premedline 1966 to July 2003, Embase, Evidence Based Medicine (EBM) reviews (including the Cochrane database of systematic reviews and the Cochrane central register of controlled trials), and the SPORTDiscus database. Search terms included heat stress disorders, heat stroke, heatstroke, heat exhaustion, heat illness, and heat injury. Papers were included if they contained original data on cooling times or cooling rates in patients with heat illness, or normal subjects who were subjected to heat stress. Owing to the lack of evidence on the treatment of patients with exertional heat illness in particular, papers describing the treatment of patients with classical or environmental heat illness were also examined. The bibliographies of relevant papers were examined and cross referenced. Papers were critically appraised for the quality of evidence presented. The
In a non-randomised study, a comparison was made of immersion in iced water and placing wet towels over the torso. Although cooling rates were fastest when the wetter of the two methods was used, the difference was not statistically significant.

Immersion in iced water immersion is the preferred method of cooling in heatstroke patients. In a case series of 28 classical heatstroke patients, a cooling rate of 0.20°C/min was achieved in all patients. Of note, there was no difference in cooling rates between patients who received dantrolene and those who did not.

Table 1 Summary of controlled trials comparing different methods of cooling in heatstroke patients

<table>
<thead>
<tr>
<th>Reference, date, and country</th>
<th>Patient group and interventions</th>
<th>Study type</th>
<th>Outcomes</th>
<th>Key results</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Al-Harthi et al, 1986, Saudi Arabia</td>
<td>16 heatstroke patients ( T_r \geq 40^\circ C ), dry skin, CNS symptoms</td>
<td>Randomised controlled trial</td>
<td>Cooling time to ( T_r = 38.5^\circ C ), death</td>
<td>Mean cooling time 62 min (35–120) (BCU) and 64 min (35–120) (CM); no difference between groups</td>
<td>Randomisation technique not defined. Small numbers not justified by power calculation.</td>
</tr>
<tr>
<td>Channa et al, 1990, Saudi Arabia</td>
<td>20 classical heatstroke patients, ( T_r \geq 41^\circ C ). Either given dantrolene 2–4 mg/kg or not</td>
<td>Randomised controlled trial</td>
<td>Cooling time to ( T_r = 39.0^\circ C ), neurological outcome, mortality</td>
<td>Mean (SD) cooling time significantly lower in treatment group: 49.7 (4.4) v 69.2 (4.8) min (p&lt;0.01). No difference in outcome or mortality (all patients survived)</td>
<td>Inclusion and exclusion criteria not clear. Possible bias from different cooling methods and different doses of dantrolene.</td>
</tr>
<tr>
<td>Bouchama et al, 1991, Saudi Arabia</td>
<td>52 classical heatstroke patients with ( T_r \geq 40^\circ C ). Given dantrolene 2 mg/kg or placebo</td>
<td>Randomised controlled trial</td>
<td>Cooling time to ( T_r = 39.4^\circ C ), organ dysfunction, length of hospital stay, mortality</td>
<td>No significant difference between study group and control group in cooling time (67.9 (12.4) v 69.0 (10.5) min), organ dysfunction, length of hospital stay or mortality</td>
<td>Better study design. Powered to detect difference in cooling time of 30 min.</td>
</tr>
<tr>
<td>Armstrong et al, 1996, USA</td>
<td>21 exertional heatstroke patients, cooled either by iced water immersion or wet towels</td>
<td>Non-randomised comparative trial</td>
<td>Cooling rates to unspecified target</td>
<td>Cooling rate 0.20°C/min for iced water, 0.11°C/min for wet towels</td>
<td>Non-randomised, large potential for bias. No outcome target given. Flawed comparison</td>
</tr>
</tbody>
</table>

CNS, Central nervous system; BCU, body cooling unit; CM, conventional methods; \( T_r \), rectal temperature.
<table>
<thead>
<tr>
<th>Table 2</th>
<th>Summary of papers describing case series and experimental cooling models</th>
</tr>
</thead>
<tbody>
<tr>
<td>Author, date, and country</td>
<td>Patient group and interventions</td>
</tr>
<tr>
<td>Wyndham et al, 1959, South Africa</td>
<td>6 healthy volunteers exercised until $T_r$ 40°C, cooled by immersion or evaporation</td>
</tr>
<tr>
<td>Weiner &amp; Khogali, 1980, UK</td>
<td>6 healthy volunteers exercised until $T_r$ 39.5°C, then cooled by immersion in 15°C water, cold air spray or warm air spray (BCU)</td>
</tr>
<tr>
<td>Kielblock et al, 1986, South Africa</td>
<td>5 healthy volunteers exercised until $T_r$ reached 2°C above baseline, then subjected to different methods of cooling (see results)</td>
</tr>
<tr>
<td>Clapp et al, 2001, USA</td>
<td>5 healthy volunteers exercised until $T_r$ 38.8°C, then subjected to different methods of cooling (see results)</td>
</tr>
<tr>
<td>Mitchell et al, 2001, USA</td>
<td>10 healthy volunteers exercised to preset limits, then cooled using 4 methods (see results)</td>
</tr>
<tr>
<td>Khogali &amp; Weiner, 1980, Kuwait</td>
<td>18 heatstroke patients cooled in a BCU</td>
</tr>
<tr>
<td>Hart et al, 1982, USA</td>
<td>28 classical heatstroke patients. All cooled by iced water immersion or ice massage if immersion not possible</td>
</tr>
<tr>
<td>Vicario et al, 1986, USA</td>
<td>30 heatstroke patients, cooled by various means depending on physician preference</td>
</tr>
<tr>
<td>Graham et al, 1986, USA</td>
<td>14 classical heatstroke patients, cooled by evaporative methods. Ice also used around torso</td>
</tr>
<tr>
<td>Al-Aska et al, 1987, Saudi Arabia</td>
<td>25 classical heatstroke patients cooled with simplified cooling bed</td>
</tr>
<tr>
<td>Poulton &amp; Walker, 1987, USA</td>
<td>3 heatstroke patients (2 exertional, 1 classical), cooled by helicopter downdraft</td>
</tr>
<tr>
<td>Costrini, 1990, USA</td>
<td>27 patients with exertional heat illness, all cooled by iced water immersion</td>
</tr>
<tr>
<td>Harowitz, 1989, USA</td>
<td>Heatstroke patient cooled by iced peritoneal lavage</td>
</tr>
</tbody>
</table>

BCU, Body cooling unit; $T_r$, rectal temperature; $T_c$, tympanic temperature; $T_c$, core temperature.
Evaporative methods
Evaporative cooling involves the removal of clothing, spraying tepid water over the patient, and facilitating evaporation and convection with the use of a fan. This was shown in the first published study of its kind to be better than other methods of cooling in normal volunteers. The basic idea was modified into a more sophisticated model termed a body cooling unit, involving water sprayed at 15°C being mixed with warm air flow to maintain skin temperature at 32–33°C. Theoretical advantages of this include reducing peripheral vasoconstriction and thereby allowing heat to be lost more effectively. In a randomised controlled trial of classical heatstroke patients, the body cooling unit was compared with conventional methods of cooling (covering the patient in a wet sheet, spraying tap water on to the sheet, and using fans to blow air over the patient), but no difference in cooling time was found. This comparison was also flawed, in that it compared two very similar methods of cooling with no reference made to iced water immersion therapy.

In another study, the body cooling unit was shown to be better than other methods of cooling in normal volunteers, achieving rapid cooling with a mean rate of 0.31°C/min, but in a case series of 18 heatstroke patients achieved a mean cooling rate of only 0.05°C/min, with cooling times (to T<39°C) ranging from 30 to 300 minutes. In another case series, a simplified cooling bed achieved slightly better results, with a mean cooling time of 40 minutes (rate 0.09°C/min).

Other cooling methods
Immersing the hands and forearms in cold water results in reduction of heat stress in normal subjects, but has not been evaluated in the treatment of heatstroke patients. The placement of ice packs in the axillae, groin, and neck has been recommended as an easy method to use in the field, modifying to a more sophisticated model termed a body cooling unit involving water sprayed at 15°C being mixed with warm air flow to maintain skin temperature at 32–33°C. Theoretical advantages of this include reducing peripheral vasoconstriction and thereby allowing heat to be lost more effectively. In a randomised controlled trial of classical heatstroke patients, the body cooling unit was compared with conventional methods of cooling (covering the patient in a wet sheet, spraying tap water on to the sheet, and using fans to blow air over the patient), but no difference in cooling time was found. This comparison was also flawed, in that it compared two very similar methods of cooling with no reference made to iced water immersion therapy.

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Dantrolene
Dantrolene is an agent that impairs calcium release from the sarcoplasmic reticulum and by doing so reduces muscle excitation and contraction. It is used in the treatment of malignant hyperthermia and neuroleptic malignant syndrome, reducing heat production that occurs as a result of muscle rigidity or hypertonicity typical of these conditions. It has been suggested that similar pathophysiological mechanisms underlie heat illness, and dantrolene has been proposed as a possible means to reduce core temperature in this condition. It has been suggested that similar pathophysiological mechanisms underlie heat illness, and dantrolene has been proposed as a possible means to reduce core temperature in this condition. It has been reported to have better results than using the body cooling unit, although this case series only involved three patients (mean cooling time to T<38.5°C 24 minutes, rate 0.10°C/min), and the method is clearly not generally available. Invasive methods of cooling include gastric, peritoneal, and bladder lavage with cold water. These have been investigated in animal models, but the only data in human subjects come from a case series where gastric lavage is described, and a single case report, when cooling was achieved in a patient resistant to evaporative techniques.

The role of invasive cooling methods has therefore not been fully established.

DISCUSSION
As is evident from this collection of the available data, there is conflicting evidence as to the best form of cooling in heatstroke patients. Treatment should start with an assessment of airway, breathing, and circulation, and measurement of rectal temperature. According to the best evidence currently available, it would appear that immersion in iced water is the most effective method of whole body cooling, and should be used where possible. However, it may not be practical from a logistic or clinical perspective, and treatment may have to be tailored to the clinical situation. For patients with a reduced level of consciousness, it may prove hazardous and is not recommended unless specific facilities allowing continued intensive medical care are available.

If immersion is unavailable or inappropriate, cooling may necessarily involve a combination of evaporative cooling techniques and other methods such as immersion of the extremities in cold water. At the roadside of an endurance event, this may be the most appropriate method of cooling. Future work should include a prospective randomised trial comparing iced water immersion with evaporative techniques in exertional heat illness patients to clarify the optimal method.

There is no clear evidence to support the use of dantrolene in the treatment of exertional heatstroke, and the priority, after an assessment of airway, breathing, and circulation, should be to institute external cooling methods to reduce core temperature as quickly as possible. Other suggested treatments such as the use of antipyretics and immunomodulatory agents have not yet been evaluated in human subjects.

This review was essentially limited to human studies, and data from animal studies have not been included. It may be subject to publication bias, and has included papers from predominantly English Language journals. The distinction has been drawn between those papers describing cooling in heatstroke patients and those involving normal volunteers exposed to experimental conditions. It should be stressed that experiments in which cooling rates are measured in normal subjects who have been exercising have limited applicability to treating heatstroke patients whose thermo-regulation mechanisms have failed. The treatment of classical heat illness patients has also been included, although whether this can be extrapolated to patients with exertional heat illness is not clear.

Comparison of papers was made more difficult by the different outcome measures used by different groups, but where possible cooling times and rates have been extracted and compared. The lack of robust evidence highlights the requirement for a large, well designed, randomised controlled trial comparing iced water immersion with evaporative techniques for the treatment of heatstroke.
CONCLUSIONS

The treatment of exertional heatstroke should begin with an assessment of airway, breathing, and circulation, and initiation of resuscitation if necessary. Subsequently whole body cooling should be the priority. Where possible, patients should be cooled using iced water immersion, although, if this is not possible, a combination of other techniques may be used. There is no evidence to support the use of dantrolene in these patients.

Further work should include a randomised trial comparing immersion and evaporative therapy in heatstroke patients.

Competing interests: none declared

REFERENCES


The author’s review of the management of exertional heat illness clearly highlights the problem in deciding the best treatment for this group of patients, who are typically young and healthy but who have a high mortality and morbidity, related directly to the duration of the temperature rise.

With regard to the best form of treatment, there are two camps, equally split between immersion and evaporative therapy. The evidence presented here appears to support the use of immersion in ice water, while acknowledging the limitations both in terms of the quality of evidence available and the practicalities of using this technique.

This is yet another area of sports medicine in which the answer to a seemingly simple question is still unknown, and presents an area in need of a well conducted randomised trial.